

## AVAILABLE BENEFIT PLANS FOR 2008

Regular AccessTN category subject to 6 months pre-existing conditions waiting period, see rates page 8

The Portability category has no waiting period for pre-existing conditions but has a higher premium, see page 10

| AccessTN<br>OUTLINE OF PPO MEDICAL BENEFITS<br>(see Plan Document for more detail)                                                                                                                               |  | Plan 1000<br>“premium<br>assistance-eligible”                                                                                                 | Plan 2500<br>“health savings<br>account-eligible”                           | Plan 5000<br>“high deductible”<br>Not HSA-eligible                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| PREVENTIVE CARE- specific services only                                                                                                                                                                          |  | 100% In-Network                                                                                                                               | 100% In-Network                                                             | 100% In-Network                                                             |
| This is first dollar coverage for specific wellness services such as an annual well woman exam, preventive screenings and an annual physical, not subject to deductible or co-insurance.                         |  |                                                                                                                                               |                                                                             |                                                                             |
| DEDUCTIBLE per plan year:                                                                                                                                                                                        |  | In-network<br>Out-of-network                                                                                                                  | \$1,000<br>\$2,000                                                          | \$2,500<br>\$2,500                                                          |
| PRESCRIPTION DRUGS - subject to additional limitations; Plans 1000 & 5000 not subject to deductible                                                                                                              |  | No deductible for outpatient drugs                                                                                                            | Deductible applies to drugs                                                 | No deductible for outpatient drugs                                          |
| Generic Drugs                                                                                                                                                                                                    |  | \$10 co-pay (cost if less)                                                                                                                    | 20 % co-insurance subject to deductible, and out-of-pocket limit;           | \$15 co-pay (cost if less)                                                  |
| Preferred Brand Drugs                                                                                                                                                                                            |  | 25% co-insurance – min. of \$25, max. of \$50                                                                                                 |                                                                             | 30% co-insurance – min. of \$30, max. of \$75                               |
| Non-Preferred Brand Drugs                                                                                                                                                                                        |  | 50% co-insurance - min. of \$50, max. of \$100                                                                                                | Non-preferred brands are <u>not</u> covered.                                | 60% co-insurance - min. of \$60, max. of \$150                              |
| COVERED EXPENSES, as specified in Plan Document subject to maximum allowable charge (MAC)                                                                                                                        |  | 80% in-network<br>60% out-of-network                                                                                                          | 80% in-network<br>60% out-of-network                                        | 80% in-network<br>60% out-of-network                                        |
| PRE-EXISTING CONDITIONS- reduced benefit for 6 months – limitation does not apply to preventive care, prescription drugs, or outpatient mental health counseling; limitation does not apply to Portability plans |  | 50% in-network<br>50% out-of-network during first 6 months of coverage only                                                                   | 50% in-network<br>50% out-of-network during first 6 months of coverage only | 50% in-network<br>50% out-of-network during first 6 months of coverage only |
| Maternity benefits                                                                                                                                                                                               |  | Excluded during 12 month waiting period                                                                                                       | Excluded during 12 month waiting period                                     | Excluded during 12 month waiting period                                     |
| Chiropractic benefits                                                                                                                                                                                            |  | Subject to guidelines                                                                                                                         | Subject to guidelines                                                       | Subject to guidelines                                                       |
| Emergency services (in-network or out-of-network)                                                                                                                                                                |  | 80% of reasonable charges                                                                                                                     | 80% of reasonable charges                                                   | 80% of reasonable charges                                                   |
| Emergency Room (ER) co-payment per visit – waived if admitted (Note: co-payment required even if out-of-pocket expenses have been met, except HSA)                                                               |  | \$50 co-payment per visit in addition to co-insurance                                                                                         | subject to deductible and co-insurance requirements                         | \$75 co-payment per visit in addition to co-insurance                       |
| Maximum Annual Out-of-Pocket Expense – does not apply to pre-existing conditions during first 6 months; does not apply to out-of-network services or ER copays; does not apply to pharmacy except for Plan 2500  |  | \$5,000                                                                                                                                       | \$5,000                                                                     | \$10,000                                                                    |
| Maximum Annual Benefits, except organ transplant                                                                                                                                                                 |  | \$200,000                                                                                                                                     | N/A                                                                         | \$200,000                                                                   |
| Supplemental Organ Transplant benefit (plans 1000 & 5000 only)                                                                                                                                                   |  | \$100,000                                                                                                                                     | \$100,000 max                                                               | \$100,000                                                                   |
| Maximum Lifetime Benefits - subject to prior benefits incurred in another state high risk pool(s)                                                                                                                |  | \$1,000,000                                                                                                                                   | \$1,000,000                                                                 | \$1,000,000                                                                 |
| Substance Abuse Treatment Limitations                                                                                                                                                                            |  | Lifetime maximums: Two inpatient stays – maximum of 28 days per stay.<br>Two inpatient stays for detoxification – maximum of 5 days per stay. |                                                                             |                                                                             |
| ANNUAL LIMITS FOR SPECIFIC BENEFITS                                                                                                                                                                              |  |                                                                                                                                               |                                                                             |                                                                             |
| Pharmacy                                                                                                                                                                                                         |  |                                                                                                                                               | \$50,000 max                                                                |                                                                             |
| Inpatient - non-emergent service must be preauthorized                                                                                                                                                           |  |                                                                                                                                               | 45 days                                                                     |                                                                             |
| Inpatient Rehabilitation Facility                                                                                                                                                                                |  |                                                                                                                                               | 45 days                                                                     |                                                                             |
| Outpatient Rehabilitation Facility                                                                                                                                                                               |  | 45 days                                                                                                                                       | 45 days                                                                     | 45 days                                                                     |
| Outpatient Physical Therapy, Occupational Therapy, Speech Therapy                                                                                                                                                |  | 45 sessions subject to Plan guidelines                                                                                                        | 45 sessions subject to Plan guidelines                                      | 45 sessions subject to Plan guidelines                                      |
| Skilled Nursing Facility (Following approved hospitalization. Prior authorization required.)                                                                                                                     |  | 45 days                                                                                                                                       | 45 days                                                                     | 45 days                                                                     |
| Home Health Care                                                                                                                                                                                                 |  | 30 visits                                                                                                                                     | 30 visits                                                                   | 30 visits                                                                   |
| Durable Medical Equipment                                                                                                                                                                                        |  | \$3,000 Max                                                                                                                                   | \$3,000 Max                                                                 | \$3,000 Max                                                                 |
| Inpatient Mental Health/ Substance Abuse                                                                                                                                                                         |  | 30 days                                                                                                                                       | 30 days                                                                     | 30 days                                                                     |
| Outpatient Mental Health/ Substance Abuse                                                                                                                                                                        |  | 45 sessions                                                                                                                                   | 45 sessions                                                                 | 45 sessions                                                                 |

Benefit Plans subject to change by AccessTN Board. Plan reimbursement based on the maximum allowable charge (MAC). You will be responsible for the deductible and any applicable co-payment or co-insurance amounts. If non-network providers are used, you will also be responsible for payment of charges above the MAC.

## Monthly Premiums for Regular AccessTN Eligibility

### Plan 1000: \$1,000 deductible

| Age   | Target Weight or Below |              | Above Target Weight |              |
|-------|------------------------|--------------|---------------------|--------------|
|       | Non Tobacco User       | Tobacco User | Non Tobacco User    | Tobacco User |
| <30   | \$387                  | \$445        | \$430               | \$494        |
| 30-39 | \$450                  | \$517        | \$500               | \$574        |
| 40-49 | \$546                  | \$628        | \$607               | \$698        |
| 50-59 | \$649                  | \$747        | \$722               | \$830        |
| 60-64 | \$766                  | \$881        | \$851               | \$979        |
| 65+   | \$904                  | \$1,040      | \$1,005             | \$1,156      |

### Plan 2500: \$2,500 deductible (HSA eligible)

| Age   | Target Weight or Below |              | Above Target Weight |              |
|-------|------------------------|--------------|---------------------|--------------|
|       | Non Tobacco User       | Tobacco User | Non Tobacco User    | Tobacco User |
| <30   | \$318                  | \$366        | \$353               | \$406        |
| 30-39 | \$369                  | \$425        | \$410               | \$472        |
| 40-49 | \$449                  | \$516        | \$498               | \$573        |
| 50-59 | \$534                  | \$614        | \$593               | \$682        |
| 60-64 | \$630                  | \$724        | \$699               | \$804        |
| 65+   | \$743                  | \$855        | \$826               | \$950        |

Note: Premium Assistance of 20% to 90% is available for Plan 1000 only, for applicants who qualify with household income up to \$75,000.  
See Page 9. Subject to available funding.

### Plan 5000: \$5,000 deductible

| Age   | Target Weight or Below |              | Above Target Weight |              |
|-------|------------------------|--------------|---------------------|--------------|
|       | Non Tobacco User       | Tobacco User | Non Tobacco User    | Tobacco User |
| <30   | \$273                  | \$313        | \$303               | \$348        |
| 30-39 | \$317                  | \$364        | \$352               | \$404        |
| 40-49 | \$384                  | \$442        | \$427               | \$491        |
| 50-59 | \$457                  | \$526        | \$508               | \$584        |
| 60-64 | \$539                  | \$620        | \$599               | \$689        |
| 65+   | \$637                  | \$732        | \$708               | \$814        |

Note-

- 1) All benefit plans above subject to 6 months pre-existing conditions waiting period and 12 month waiting period for maternity coverage.
- 2) You are eligible for AccessTN or Portability over the age of 64 ONLY if you are NOT eligible for Medicare.
- 3) AccessTN is not a Medicare supplement policy.

To determine your monthly premium, first find your height and weight on the chart below.

Next, go to the tables on the left side of this page for the benefit plan you have chosen (1000, 2500, or 5000) and find the row for your age group.

Then move across the row for your age to find the column that fits you:

- If your weight is equal to or less than what is listed in the chart, use the "Target Weight or Below" columns. If your weight is more than what is listed in the chart, use the "Above Target Weight" side.
- Finally, are you a tobacco user (cigarettes, chewing tobacco, pipe or cigars) or not?

This will be the monthly premium for your beginning coverage, unless you qualify for premium assistance. If you qualify, you can use the tables on page 9 in the same way as is described here.

#### Defining Target Weight at BMI of 30

| Height | Target Weight |
|--------|---------------|
| 4' 10" | 142           |
| 4' 11" | 147           |
| 5' 0"  | 152           |
| 5' 1"  | 157           |
| 5' 2"  | 163           |
| 5' 3"  | 168           |
| 5' 4"  | 173           |
| 5' 5"  | 179           |
| 5' 6"  | 185           |
| 5' 7"  | 190           |
| 5' 8"  | 196           |
| 5' 9"  | 202           |
| 5' 10" | 208           |
| 5' 11" | 214           |
| 6' 0"  | 220           |
| 6' 1"  | 226           |
| 6' 2"  | 232           |
| 6' 3"  | 239           |
| 6' 4"  | 245           |
| 6' 5"  | 252           |